TEXAS
Health and Human Services

Form 1578
March 2018-E

Qualified Income Trust (QIT) Copayment Agreement

Applicant/Member Name	Medicaid No.
Trustee Name	Total QIT Copayment Amount Available Monthly
Trustee Mailing Address	

Services Purchased Through QIT Copayment

Specific Service Purchased with QIT Copayment	QIT Copayment Amount	Service Unit Rate	Units Purchased	Amount of Copayment Paid to Provider for Service

Copayment Agreement: I understand the trustee of the Qualified Income Trust (QIT) established on my behalf will be required to pay the providers of my STAR+PLUS Home and Community Based Services (HCBS) program directly for services that are to be purchased through my copayment. I understand that I must assure the provider is paid the copayment by the 10th day of each month in which I receive STAR+PLUS HCBS program services. I agree to notify my trustee of this requirement and understand that failure to pay the copayment will result in termination of my STAR+PLUS HCBS program services and Medicaid benefits.

Signature - Applicant/Member/Legally Authorized Representative/Authorized Representative | Date

Signature - Witness | Date

Name/Title or Relationship of Witness

Acknowledgement Signature of Trustee | Date

Signature - Managed Care Organzation Staff Person | Date

Note: Failure to sign this agreement and the individual service plan (ISP) developed considering the QIT copayment will result in denial of the STAR+PLUS HCBS program application or services.